

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675714	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER Tomball Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 815 N Peach St Tomball, TX 77375	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interviews and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for all 89 residents. The facility failed to demonstrate its measures to minimize the risk of legionella (bacteria naturally found in water that can cause a type of lung infection called legionellosis (legionnaires' disease and Pontiac fever; a milder flu-like illness) when people inhale tiny water droplets containing the bacteria) in the building's water system, when the facility's Water Management Program team failed to develop and implement an adequate water management policy and procedure to reduce the risk of growth and spread of legionella and other opportunistic pathogens in the building water system 02/19/2026. This failure could place residents at risk of outbreaks of legionellosis. Findings included: Record reviews of the facility's Infection Prevention and Control Program dated 11/06/2024, revealed the following: .Water Management: a. A water management program has been established as part of the overall infection prevention and control program. b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c. The Maintenance Director serves as the leader of the water management program .Record reviews of the facility's Legionnaires Monitoring Protocol dated 10/19/2015, revealed the following: The facility did not develop and implement a water management program that considers the ASHRAE industry standard and the CDC toolkit. The facility did not have a risk assessment to identify where legionella could grow and spread in the facility water system. The policy did not have a procedure on how to use the control measures to control the introduction and/or spread of legionella in the building water system. The policy did not include control limits (the maximum value, minimum value, or range of values that are acceptable for the control measures that you are monitoring to reduce the risk for legionella growth and spread) and parameters. The policy did not have monitoring procedures to include: a. Specified and documented environmental testing protocols for legionella. b. Established control limits acceptable for the control measures the facility monitored to reduce the risk for legionella growth and spread. The policy did not have established ways to intervene when control limits were not met or when there was a case of healthcare-associated legionellosis in the facility. During an interview on 02/19/2026 at 2:33 p.m., the facility's Regional Director of Operations, the IDON and the Maintenance Director stated they were not aware the LWMP was inadequate to prevent the growth and spread of legionella in the building water system. They stated they were not aware the plan did not have:- A risk assessment to identify where legionella could grow and spread in the facility water system,- procedures to explain how to use the control measures,- what were the acceptable control limits and parameters,- what were the monitoring procedures,- what were the testing protocols,- and what were the established ways to intervene when control limits were not met or when there was a case of healthcare-associated legionellosis in the facility. The facility's Administrator, who has been working at the facility for a week, stated the Water Management Program team should have established and maintained an adequate program to prevent the growth and spread of legionella in the building.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 7 residents (Resident #33, Resident #85) reviewed for medication storage and labeling. The facility failed to ensure nurses dated Residents #33 and 85's opened insulin glargine (a medication prescribed to help the body manage blood sugar levels) pens and discarded them within 28 days of opening, on [DATE]. This failure could place residents at risk of receiving medications that were less effective or expired and the risk of contamination or chemical degradation (change of a substance into something else, often making it weaker, useless, or harmful). Findings included: Record review of Resident #33's Provider Orders dated [DATE], revealed an active order to receive insulin glargine 100 units/ml multiple-dose pen. Inject 15 units SQ (under the skin) at bedtime for diabetes (a disease in which the body cannot make or properly use insulin). Record review of Resident #85's Provider Orders dated [DATE], revealed an active order to receive insulin glargine 100 units/ml multiple-dose pen. Inject 10 units SQ every 12 hours for diabetes. During an observation of Hall A's medication cart and interview on [DATE] at 2:03 p.m., revealed, staff opened and dated 2 insulin glargine, 100 units/ml multiple-dose pens and kept them in the medication cart beyond 28 days of the opening date. Staff opened and dated an insulin pen that belonged to Resident #33 on [DATE] and opened and dated a second insulin pen that belonged to Resident #85 on [DATE]. LVN A stated all nurses should have checked the pens dates before each administration and discarded them after 28 days of opening. LVN A added if nurses kept using the insulin pens after 28 days of opening, residents might have received insulin that was less effective in controlling their blood sugar levels. During an interview on [DATE] at 4:23 p.m., the IDON stated he expected all nurses to check insulin pens for opening dates before each administration and discard them after 28 days of opening. The IDON added if nurses kept using the insulin pens after 28 days of opening, residents might have received insulin that did not work as prescribed. Record review of the facility's Storage of Medications Policy dated [DATE], revealed .Drugs dispensed in the manufacturer's original container will carry the manufacturer's original expiration date. Once opened, these products will be acceptable to use until the manufacturer's expiration date is reached and unless the medication is: .iii. An item or which the manufacturer has specified a usable duration after use. Record review of the most current manufacturer's guide for insulin glargine pens dated [DATE], revealed staff must throw away all opened pens after 28 days of first use, even if there is insulin left in the pen.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the medication error rate did not exceed 5% for 3 of 7 residents (Residents #41, #46, #96) reviewed during medication administration. Staff administered 26 medications with 3 errors, which resulted in a medication error rate of 11.54%. The facility failed to ensure physician orders were followed for preparing MiraLAX with a specific amount of water for Resident #41 and Resident #46 on 02/18/2026 and 02/19/2026. The facility failed to ensure staff followed physician orders for IV medication administration by not obtaining flushing orders before and after IV medication administration for Resident #96 on 02/19/2026. The failure could place residents at risk of receiving less than optimal results from their medication regimen, stomach irritation and fluid overload (when body retains too much water). The failure could result in inadequate medication delivery and harm related to improper IV therapy. Findings included: Record review of Resident #96's undated admission record revealed a [AGE] year-old female with an initial admission on [DATE] and most recent admission on [DATE]. Resident #96 had diagnoses of sepsis, respiratory failure, pneumonia, aphasia, and enlarged lymph nodes. Record review of Resident #96's Care Plan initiated on 09/04/2023 and revised on 09/13/2023 read, resident was at risk for infection/signs and symptoms of viral respiratory infection. The interventions read, encourage/educate resident/resident family on vaccinations for respiratory viruses such as, COVID-19, Influenza, pneumonia, etc. Observe for and promptly report signs and symptoms: fever, coughing, shortness of breath, or other respiratory issues. Record review of Resident #96's Quarterly MDS dated [DATE] revealed a BIMS score of 8 with moderate cognitive impairment, meaning the resident has severe impairment but still able to participate meaningfully in an interview with support. Record review of Resident #96's MAR dated 02/18/2026 revealed to begin Vancomycin HCl Intravenous Solution 500 MG/100ML. Use 1 dose intravenously every 12 hours for IV ABT related to Pneumonia until 03/07/2026. There were no flushing orders Sodium Chloride Solution 0.9% to be completed before or after treatment. In observation on 02/19/2026 at 7:40am RN O administered Vancomycin HCl Intravenous Solution 500 MG/100ML to Resident #96. RN O flushed the resident's IV line with 10mL of 0.9% sodium chloride solution. After completing the infusion, RN O again flushed the IV line with 10mL of 0.9% sodium chloride solution. In an interview and observation on 02/19/2026 at 7:48am with RN O reviewed the MAR and the physician order with this surveyor, in which there was no order for flushing the IV line with 10mL. RN O stated it was nurse practice when administering IV therapy to flush the IV line and because there was no flushing order, she would just obtain an order from the doctor. In an interview on 02/19/2026 at 8:57am with the IDON stated the expectation for administering medication should be followed according to the doctor order. It was standard practice to flush, but the order should be verified before administering. The risk of flushing IV lines without an order was an adverse effect and bad practice. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #46 Record review of Resident #46's Physician Orders, dated 09/11/2023, revealed an active order of polyethylene glycol 3350 oral (by mouth) powder 17 gm/scoop. Give 1 scoop by mouth two times a day for constipation. The order did not specify how much water to mix the powder with. During an observation on 02/18/2026 at 8:45 a.m., MA A poured and mixed polyethylene glycol powder with water and attempted to give it to Residents #46. Resident #41 Record review of Resident #41's Physician Orders, dated 11/14/2025, revealed an active order of polyethylene glycol 3350 oral powder 17 gm/scoop. Give 1 scoop by mouth in the morning for constipation. The order did not specify how much water to mix the powder with. During an observation on 02/19/2026 at 9:51 a.m., MA A poured and mixed polyethylene glycol powder with water and attempted to give it to Residents #41. During an interview on 02/19/2026 at 10:57 a.m., MA A stated she should have contacted the provider to seek clarification about the water amount to mix the polyethylene glycol powder with before she gave it. She stated administering the powder with the wrong amount of water could cause health issues to residents. During an interview on 02/19/2026 at 11:24 a.m., the NP stated both polyethylene glycol orders should have included between 4 and 8 oz. of water to mix the powder with. The NP stated she expected the prescribing provider, who did not work with the facility any longer, to include the amount of water in those orders. The NP stated she expected nurses and MAs to contact the provider for clarification about medication orders when those orders missed instructions on how to use them. She stated administering the powder with the wrong amount of water could cause stomach irritation. She also stated it could also cause fluid overload and coughing for residents who had fluid restrictions on their daily fluid intake. During an interview on 02/19/2026 at 4:25 p.m., the IDON stated he expected Nurses and MAs to call the provider to seek clarifications about medication orders when those orders missed instructions on how to use them. He stated nurses and MAs should have sought clarification about the amount of water required to mix the powder with before each administration. The IDON stated using the wrong amount of water to mix the powder could prevent the medication from working as prescribed and could cause fluid overload for residents with fluid restrictions.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. The facility failed to ensure leftover food to be used later with temperature in the danger zone foods were discarded. The facility failed to ensure that food past the use by date were discarded which included 1 bag lunch dialysis used by date 2-12-26, 1 bag lunch dialysis used by date 2-13-26. A pan of corn niblets no used by date, a package of sausage use by date 2-14-26, a package of sliced swiss cheese no label no used date. The facility failed to ensure foods were stored 6 inches off the floor. Dirty can opener blade. Observation of the facility on 2-17-26 at 7:45 am revealed the following. 1. A dialysis lunch bag used by date 2-11-26 and 2-13-26. 2. A pan of corn nib lets no used by date. 3. A package of breakfast sausage use by date 2-14-26. 4. A package of shredded cheese no used by date. 5. A package of sliced swiss cheese no used by date. 6. A case of frozen ground beef in the freezer floor. 7. A pan of soft mechanical sausage with a temperature of 130.1 degrees Fahrenheit in the steam table. 8. Scoop for salt bin should not be in the food bin. Interview with the dietary food service manager on 2-17-26 @ 8:00 AM, revealed that the following foods were stored in the refrigerator to be used for later date should be discarded prior to use by date. She stated the leftover food with danger food temperature 40 degrees Fahrenheit to 140 degrees Fahrenheit should have been discarded. She further stated that she will in -service dietary staff on proper handling, storing, dating leftover food for compliance.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 9 residents (Resident #91) on the 200 hall. The facility failed to create a sanitary environment by leaving two soiled briefs on the floor, in Resident #91's room on 02/17/2026. This failure could result in high risk of cross-contamination. Findings included: Record review of Resident #91's undated face sheet revealed she was a [AGE] year-old female with an initial admission date of 11/22/2026 and most recent admission on [DATE]. Resident #91 has diagnoses of lack of coordination, polyneuropathy (many nerves in different parts of the body become damaged), abnormal posture, absence of left leg above the knee, congestive heart failure, anxiety, and major depressive disorder. Record review of Resident #91's Initial MDS assessment dated [DATE] revealed a BIMS score of 9. Resident #91's BIMS demonstrated moderate cognitive impairment, which could reflect problems with thinking and memory. Record review of Resident #91's Care Plan revised on 12/01/2025 revealed resident was incontinent of bowel/bladder. The interventions read, check frequently for wetness and soiling, and change as needed. In an observation on 02/17/2026 at 8:17am in Resident #91's room on the 200 hall revealed two soiled briefs on the floor, trash on the floor, and multiple bed pads in the trash bin. In an interview on 02/17/2026 at 10:56 am with Resident #91 stated she had just come back from the hospital. She normally throws used briefs on the floor, and the staff will come pick them up. Resident #91 stated that she has a problem with her hands and couldn't fold it. Resident #91 didn't state the risk of the soiled briefs being left on the floor, but stated when she presses the call light button, staff will not come, which was why she would leave the brief on the floor and clean herself up. In an interview on 02/17/2026 at 11:21 am with the IDON stated the expectation for cleanliness in the resident rooms and throughout the facility was to conduct rounds within a two-hour period and for staff to come behind residents and clean up. The risk of soiled briefs being left on the floor could cause a break in infection control. In an interview on 02/17/2026 at 11:53am with the ADON stated the expectation for cleanliness in the resident rooms was the aides should be going behind residents and making sure nothing was on the floor or in the trash. Rounds should be made every two hours to ensure residents were not soiled and briefs were not being left around. The resident doesn't usually have this behavior, as this was the first time she had left soiled briefs on the floor. ADON assured cleanliness, infection control, and call lights will be re-educated to Resident #91. The risk of soiled briefs being left on the floor was contamination. In an interview on 02/19/2026 at 2:04pm LVN A stated for soiled briefs with incontinence care, they should be put into a bag and into a barrel to be taken out by staff. The expectation for cleanliness would be conducting rounds and making sure barrels were being taken out along with picking up trash. The risk of soiled briefs being left on the floor was unsanitary and could possibly cause issues in areas of infection control. In an interview on 02/19/2026 at 2:16pm with EVS F stated resident trash was emptied once a day, but nurse oversees taking out their own trash in resident rooms. The expectation was daily cleaning of resident rooms, to include mopping and disinfecting. The risk of soiled briefs being left on the floor was possible infection such as Clostridioides difficile (bacteria that can cause diarrhea) that could be carried through bodily fluid. In an interview on 02/19/2026 at 2:34pm CNA B stated for soiled briefs, they should be placed into a plastic bag and then taken to the barrel. The expectation for cleanliness was to keep things tidy and housekeeping ensure the rooms were disinfected. The risk of soiled briefs being left on the floor was becoming sick, a resident could become depressed or have a fall. Record review of Resident Rights policy dated 02/23/2016 reflects. Policy: The facility will inform the resident both orally and in writing in a language that the resident understands his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. 8. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a comprehensive plan is reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments reviewed for 1 of 23 (Resident #94) residents. The facility failed to revise Resident #94's care plan after completing the comprehensive assessment to reflect Resident #94 pocketing food in the mouth, being lethargic, and having a decreased appetite. The failure could result in the resident not receiving proper care. Findings included: Record review of Resident #94's undated face sheet revealed he was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE] and then 01/01/2026. Resident #94 has diagnoses of protein-calorie malnutrition, dysphagia (difficulty swallowing), dementia, gastro-esophageal reflux disease without esophagitis (heartburn), muscle weakness, epidural hemorrhage without loss of consciousness (dangerous lucid head injury that causes arterial bleeding between the skull and dura mater) and Alzheimer's. Record review of Resident #94's Care Plan initiated date 07/15/2025 with no updates after this date read resident was on mechanical soft and thin liquids and at nutritional and hydration risk related to diet restrictions. Intervention read, serve diet as ordered. Monitor intake and record every meal, provide and serve supplements as ordered, dietary manager to discuss food preferences with resident or family upon admission and then as needed to meet dietary needs, registered dietitian to evaluate and make diet/supplements change recommendations as needed. Record review of Resident #94's Quarterly MDS assessment dated [DATE] revealed resident has a BIMS score of 01, reflects severe cognitive impairment, indicating the resident is not able to provide correct responses. Functional abilities for eating are scored 02, which means the resident does require substantial/maximal assistance, more than half the effort to eat. The helper lifts or holds trunk of limbs and provides half the effort. Section K0100 revealed Resident #94 did not have a swallowing disorder and showed no signs or symptoms. Section K0300 revealed Resident #94 loss of 5% or more in the last month or loss of 10% or more in the last 6 months scoring was 0, no or unknown. Record review of Resident #94's Nutrition assessment dated [DATE] revealed nutrition orders were no added salt, mechanical soft texture, and thin liquids diet. Eating ability was extensive assistance, should be in the dining room, and should oral intake 26-50% of food. Monitoring/Evaluation read 1. Nsg/IDT verify wt. Weigh wkly x 4 wks; continue if patten wt loss. 2. Monitor meal records/intake for meal intake less than 51-100% of most meals; verify alternates provided then intake less than 51-100%. Signed by RD S on 12/20/2025, which was not updated into the care plan. Record Review of Resident #94's MAR dated 12/27/2025 revealed Med plus 2.0 three times a day for supplement 90ml with medication pass may use med pass 2.0 or house shake. Protonix Tablet Delayed Release 40MG (Pantoprazole Sodium), give 1 tablet by mouth in the morning for GI bleed. Ascorbic Calcium Oral Tablet 500 MG (Ascorbic Acid), give 1 tablet by mouth in the morning for supplement. Record review of Resident #94's Follow Up on 01/15/2026 with NP P read advance care planning with patient/family/member/surrogate the following treatment preferences were discussed as follows: Discuss power of attorney and living will. Discussed IV fluids and enteral feeding. Record review of Resident #94's SBAR Communication dated 01/18/2026 by LVN A read resident has had the following change in condition: decreased appetite, pocketing food, and lethargic. Since the change/symptoms started, it has gotten worse. This condition, symptom, or sign has occurred before. NP S was notified, assessed and recommended to continue monitoring and will update current NP tomorrow about possible hospice. RP was contacted. Record review of Resident #94's Progress Note dated 01/19/2026 by MA A read Med plus 2.0 three times a day for supplement 90 ml with medication pass may use med pass 2.0 or house shake PRN as alternate - unable to swallow nurse notified. Ascorbic Acid Oral Tablet 500MG give 1 tablet by mouth in the morning for supplement - unable to swallow nurse notified, which was not (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated into the care plan. Record review of Resident 94's Progress Note dated 01/21/2026 by LVN A read poor appetite and weakness noted. NP & RP aware. Record review of Resident #94's Progress Note dated 01/21/2026 by LVN A read this nurse observed resident looking lethargic. Two CNA and this nurse helped transport resident to bed and obtain vitals. Low o2 and pulse noted. Notified DON and lowered resident to the floor. NP was present. This nurse started CPR for 3 rounds of 30 compression and took over giving 2 breaths after 30 compressions. 911 was called by ADON. AED pad were placed while DON was giving compressions. EMS arrived and took over. EMS called time of death at 12:31pm. Called RP and spoke with him regarding resident passing away. RP called this nurse with funeral arrangements and will be out to the facility collect belonging. Record review of Resident # 94's Follow Up Question Report dated 02/18/2026 for multiple meal intake dates. 01/15/2026 at 12:03pm, 0-25% of meal was eaten. 01/18/2026 at 8am, 0-25% of meal was eaten. 01/18/2026 at 11am, 26-50% of meal was eaten. 01/19/2026 at 8am, 0-25% of meal was eaten. 01/19/2026 at 11am, 0-25% of meal was eaten. 01/21/2026 at 11:51am, 02-25% of meal was eaten. In interview on 02/18/2026 at 10:38am with RD S stated she does not recall a recent change in condition for Resident #94 for decreased appetite, pocketing food, and being lethargic. For evaluations, she was notified via email or telephone call and after she will relay her concerns to the DON or ADON along with the Dietary Manger for updated changes. RD S provided communication forms with diet changes for all residents in the facility from December 2025- January 2026 and it did not reveal any changes for Resident #94's diet or any updated recommendations. In attempts on 02/18/2026 at 10:56am to contact NP S by telephone and e-mail, no response was received. In an interview on 02/18/2026 at 11:26am with NP P stated the last time she saw Resident #91 was on 01/15/2026 for his quarterly visit and blood pressure medications, but there was a weekend NP that may have seen the resident on 01/18/2026. She was not made aware of any recent change in conditions for Resident #94 pocketing food, decreased appetite, and being lethargic. NP P stated the resident had orders for dietary consultation and speech was working with him, but she was unsure how recent. The RP declined for the resident to have tube feeding when it was last discussed on 01/15/2026. On 01/21/2026 she was called into the room of Resident #94, as LVN A was providing CPR to the resident. For the change in condition, the follow up should have been an order for speech therapy and then a recommendation for swallow evaluation. Once the recommendations were complete, the speech therapist or MDS would follow the recommendations and the orders will be updated in the chart, interventions into the care plan. In an interview on 02/18/2026 at 11:42am with LVN A stated on 01/18/2026 she completed a change in condition for Resident #94 due to decreased appetite, pocketing food, and being lethargic. She could not recall if there were any recent changes made from the RD, but the CNAs monitor the resident's feedings and input the percentage into Kardex. She was informed the RP declined for the resident to have a g-tube and hospice care. After she completed the change in condition, someone would have informed the speech therapist regarding a consult/evaluation. Normally the DON update pull the reports or 24 hour report to alert a change has occurred before the morning meeting and that was how the team was made aware of new conditions and had previously happened the day before. The risk of the care plan not being revised after an assessment could result in a missed opportunity to properly address the residents needs of care and they could possibly decline. In an interview on 02/18/2026 at 12:34pm with P ADMN stated she was not made aware of Resident #94's change in condition but was present when the resident expired. The expectation for a change in condition was to notify the DON and the ADMN once the SBAR has been completed, recommendations can be made by the NP or MD, notify the RP, and the care plan will be revised. Once the care plan was revised, all nursing staff would have access to the change before providing care to the residents. Communication was made throughout the day, which can be verbal, e-mail, or electronically. The P DON would have been responsible for ensuring the recommendations from the SBAR were completed and followed up on and any new interventions that would have been completed by the DON to reflect the change in condition with the resident. The risk of the care plan (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Tomball Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 815 N Peach St Tomball, TX 77375	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not being revised after an assessment could result in missed adjustments needed, preventable side effects, or even neglect. In an interview on 02/18/2026 at 12:46pm with ST B stated that she does not recall conducting an assessment for Resident #94. For resident evaluations, there was an order in the electronic medical record, which she is informed by the DOR. A speech therapy evaluation requires a physicians order. Speech therapy does not assess a resident without that order. In practice, evaluations are typically initiated when a resident is unable to swallow safely or when an upgrade in diet texture does not require a speech therapy evaluation; however, an upgrade would require assessment by a speech- language pathologist to ensure the resident can safely tolerate the higher texture. The last evaluation that was completed for Resident #94 was on 07/01/2025 and the recommendations at that time were solids mechanical soft and thin liquids. In an interview on 02/18/2026 at 2:06pm with P DON stated she was not aware of a recent change in condition for Resident #94, but he did have swallowing problems. The NP and MD were notified of the change and there was a speech therapy evaluation completed, but she does not recall any new interventions. P DON stated she was responsible for updating care plans, once the SBAR was complete and all proper recommendations had been made. Once the care plan has been revised, all nursing staff can verify the updated change before caring for the residents through Kardex. The expectation was for staff to inform her of the residents having a change in condition to start notifying all needed parties to ensure the residents were evaluated. The risk of the care plan not being revised after an assessment could result in harm to the residents. In an interview on 02/18/2026 at 2:20pm with the DOR stated speech therapy services for Resident #94 were from 07/01/2025-09/18/2025. There were no referrals, recommendations, or follow ups completed after the discharge of services on 09/18/2025. Record review of facility policy for Care Plans and Care Area Assessments dated 01/21/2015, revised on 05/06/2016 reads. The purpose of this guide is to ensure that an interdisciplinary (IDT) approach is utilized in addressing the Care Area Triggers (CATs) that were generated by the completion of the Minimum Data Set (MDS) in order to effectively address the Care Area Assessments (CAAs) and ultimately achieve the completion of an effective comprehensive plan of care for each resident. All admission and Significant Change care plans that are generated by the MDS-CAAs will be initiated by a Registered Nurse (RN). All comprehensive care plans will be completed utilizing the Point Click Care electronic system. All care plans will be kept in an area that is accessible by all staff. The facility IDT members are responsible for addressing their assigned CAT/CAA triggered by the MDS at the time of MDS assessment. Acute Care Plans As acute problems or changes to intervention or goals are identified, an appropriate care plan will be developed or modified by a Nursing staff member.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that each resident received adequate supervision to prevent accidents for 1 of 23 residentsResident #43) reviewed.The facility failed to ensure adequate supervision was provided for Resident #43 while smoking. Resident #43 was outside smoking without staff supervision on 2/17/26.This failure could place the residents at risk for burns, injury, and fire hazards.Findings included:Record review of Resident #43's undated face sheet revealed he was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE]. Resident #43 has diagnoses of intermittent explosive disorder, epilepsy, lack of coordination, weakness, muscle spasm, transient ischemic attack (short period of symptoms like a stroke), and atrial fibrillation (very rapid heartbeat).Record review of Resident #43's Smoking Evaluation dated 05/20/2025 revealed resident has a BIMS score less than 12 and can make decisions regarding tasks of daily life. Resident #43 was dependent and requires assist/supervision to smoke by IDT.Record review of Resident #43's Smoking Evaluation dated 07/27/2025 revealed resident has a BIMS score equal to or greater than 12 and can make decisions regarding tasks of daily life. Resident #43 was independent and requires no supervision to smoke by IDT.Record review of Resident #43's Smoking Evaluation dated 09/25/2025 revealed resident has a BIMS score equal to or greater than 12 and can make decisions regarding tasks of daily life. Resident #43 was dependent and requires assist/supervision to smoke by IDT.Record review of Resident #43's Care Plan dated 06/27/2025 and revised on 08/21/2025 stated resident was a smoker and was at risk of injury. The interventions read, remind resident and family that all cigarettes, lighters, matches, and smoking paraphernalia must be kept at the nurse's station. The resident will be supervised while smoking on facility property to reduce the risk for smoking related injuries.In an observation on 02/17/2026 at 6:21 am, Resident #43 was observed in his wheelchair exiting the facility back door with 1 cigarette in hand and going towards the end of the building, passing the no smoking sign. Resident #43 was observed lighting his own cigarette with a lighter, which he then placed in his pocket while the cigarette remained lit.In an interview on 02/17/2026 at 6:21am, Resident #43 stated he was always smoking outside by himself and then asked who she was. The resident no longer wished to answer any questions after surveyor identified self.In an interview on 02/17/2026 at 6:23am with LVN K stated residents were not allowed to go out and smoke by themselves, they must be supervised. LVN K was not aware the resident went out the unlocked back door of the facility to smoke, until it was made aware by the surveyor. LVN K stated the door is to be always locked, but unsure who unlocked the door. The risk could be the resident falling out of the wheelchair.In an interview on 02/17/2026 at 9:40am with the ADMN stated smoking was to be supervised anytime in the designated area. Residents should not have any smoking paraphernalia, and it was to always be locked away with only staff who have access. The risk of a resident smoking unsupervised was safety.In an interview on 02/17/2026 at 12:20pm with the ADON stated residents were not allowed to smoke unsupervised. Residents were to have no smoking paraphernalia. The risk of a resident smoking unsupervised was they could possibly set themselves on fire, pass out, or have some type of injury. In an interview on 02/17/2026 at 12:21pm with the IDON stated residents were not to smoke unsupervised, if they do, they sign themselves out and were r no longer on facility grounds. Residents should not have their own smoking paraphernalia, and it was kept in a locked area where only monitoring staff have access. The risk of a resident smoking unsupervised was injury and/or the resident could burn themselves.In an interview on 02/19/2026 at 3:24pm with CNA B stated the policy for resident smoking was to ensure safety. Smoking paraphernalia was kept locked in the medication's storage room, only nurses and appointed staff for allotted smoke times have access. The risk of a resident smoking unsupervised was burning themselves.In an interview on 02/19/2026 at 3:50pm with the AD stated residents shouldn't have any (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smoking paraphernalia and it was locked in the medication storage room. The procedure while supervising residents who smoke was to check if they were required to wear an apron, provide resident with their cigarette, light it for them, make sure they're not dropping any ashes, empty the ash tray, and clean up before leaving the smoking site. The risk of a resident smoking unsupervised was burning themselves or their clothes. Record review of the facility's Smoking Policy dated 02/26/2014 with a revision dated 07/14/2023 read. Policy It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees as related to smoking. To evaluate a patient's ability to participate and exercise the privilege to smoke/Use smokeless Tobacco products while residing within the facility. 3. Facilities will have a designated Smoking/Tobacco use area. Signs will be prominently posted. Smoking is prohibited in all other areas. Safety measures for the designated smoking area will include, but not limited to: a. Protection from weather conditions (i.e., covered) b. Ashtrays made of noncombustible material and safe design c. Accessible metal container(s) with self-closing covers into which ashtrays can be emptied. d. Accessible fire extinguisher. e. Sign Prohibiting use of oxygen in the smoke area f. Type A Fire extinguisher or fire blanket 8. Staff members distribute smoking accessories to patients at center designated smoking times or when signing out of the centers. Smoking accessories are returned to the staff when the patient signs in to the facility. 16. Upon completion of the evaluation, the interdisciplinary team lead by the social worker or designee, will assess the patient's ability to understand smoking/smokeless Tobacco guidelines and handle smoking and smokeless paraphernalia. a. If the patient is determined to be an Independent Smoker, the patient may smoke without assistance at center designated times and with designated staff present. b. If the patient is determined to be a Dependent Smoker, or Dependent Smokeless Tobacco user, the patient is supervised during smoking. The resident/family is educated on the use of protective smoking equipment which may include but not limited to a protective smoking vest or apron, smoking, clips etc.		